

WYANDANCH UNION FREE SCHOOL DISTRICT

Opt Out Form

I hereby decline the following insurance coverage for the 2011-2012 school year:

Medical Coverage
(reimbursement according to contract)

Dental Coverage
(reimbursement according to contract)

Vision Coverage
(no reimbursement)

Individual Declination Family Declination

Please indicate position below:

Administrator Teacher

Clerical (attach copy of medical card) Teaching Assistant (attach copy of medical card)

Custodian (attach copy of medical card) Mechanic (attach copy of medical card)

Security Guard (attach copy of medical card) Bus Driver (attach copy of medical card)

Food Service Worker (attach copy of medical card)

I understand it is my responsibility to inform the Human Resources Department at the beginning of every school year that I am continuing to OPT OUT of the coverage indicated.

The deadline to notify Human Resources is October 1st

Signature _____ Last 4 digits of SS# XXX-XX-_____

Print Name _____ Date _____